PRINTED: 07/15/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 185399 07/01/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8005 US HWY 60 WEST HEARTLAND VILLA CARE AND REHABILITATION CENTER LEWISPORT, KY 42351 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 07/22/10 F 000 **INITIAL COMMENTS** F 000 "This Plan of Correction is prepared and submitted as required by law. By sub-A standard recertification survey was conducted mitting this Plan of Correction, Heartland 06/29/10 through 07/01/10. Deficiencies were Villa Care & Rehabilitation Center does cited, with the highest S/S being a "G". 483.25(g)(2) NG TREATMENT/SERVICES -F 322 F 322 not admit that the deficiency listed on this RESTORE EATING SKILLS SS=D form exist, nor does the Center admit to any statements, findings, facts, or con-Based on the comprehensive assessment of a clusions that form the basis for the alleged resident, the facility must ensure that a resident deficiency. The Center reserves the right who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services o challenge in legal and/or regulatory or to prevent aspiration pneumonia, diarrhea, administrative proceedings the deficiency vomiting, dehydration, metabolic abnormalities, statements, facts, and conclusions that and nasal-pharyngeal ulcers and to restore, if form the basis for the deficiency." possible, normal eating skills. F322 07/22/10 The facility will continue to ensure that This REQUIREMENT is not met as evidenced resident's who are fed by naso-gastric or gastrostomy tube receive the ap-Based on observation, Interview and record propriate treatment and services to review, it was determined the facility failed to ensure that one resident (#5), in the selected prevent aspiration pneumonia, diarrhea, sample of 12, who was fed and received vomiting, dehydration, metabolic medications through a gastrostomy tube (G-tube), abnormalities, and nasal-pharyngeal received the appropriate treatment and services ulcers and to restore, if possible, normal to prevent aspiration. Observation revealed one eating skills. nurse failed to check placement of the G-tube, prior to administration of medication. With respect to resident(s) affected by Findings Include: the alleged deficient practice: Resident #5 was assessed by the Director of Nursing A review of the facility's undated policy, "Enteral Services (DNS) on 06/29/10. No neg-Nutrition" revealed for the continuously tube-fed resident, placement should be tested every four ative outcomes were noted. The Treatto twelve hours and before medication ment Administration Record (TAR) was administration. updated to reflect assessing/evaluating placement of the gastrostomy tube prior An observation of a medication pass, on 06/29/10 to at approximately 3:40 PM, revealed Licensed Practical Nurse (LPN) #4 administered

Any deficiency statement ending-with an asterisk (%) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Event ID: 2CKZ11

Facility ID: 100679

TITLE

(X6) DATE

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION	(X3) DATE S COMPLE	
,		185399	B. WII	νG		07/0	1/2010
	PROVIDER OR SUPPLIER AND VILLA CARE AN	D REHABILITATION CENTER	<b>!</b>	8	REET ADDRESS, CITY, STATE, ZIP CODE 005 US HWY 60 WEST .EWISPORT, KY 42351		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 333	and mixed in water, LPN #4 did not cher prior to the medication of	otlc) 500 milligrams, crushed via G-tube for Resident #5. ok placement of the G-tube, on administration.  PN #4, on 06/29/10 at PM, revealed she did not ube placement with the edications. G-tube placement beginning of each shift. LPN d have checked placement, ration of the medication.  Irector of Nursing, on mately 5:30 PM, revealed hould be checked, prior to the y medication.  DENTS FREE OF ERRORS  sure that residents are free of		3333	medication administration on 06 With respect to residents having tial to be affected by the alleged practice: 07/01/10, residents To reviewed and updated to reflect assessing/evaluating placement gastrostomy tube prior to medical administration. With respect to measures to effect systemic changes to ensure the deficient practice does not recur was re-educated on 06/29/10 by to include administration of medical gastrostomy tube. All nurse rewas completed by the DNS on 00 on medication administration via trostomy tube. The Medication istration Record (MAR) or TAR is assessing/evaluating placement gastrostomy tube prior to medical	g the potent deficient AR's were tof the ation alleged the DNS lication via education 06/29/10, a gas-Admin-will reflect of the	07/03/10
	by: Based on observation review, it was determensure one resident sample, was free from the errors. Resident #13 at approximately 4:4 order for Hydrocodo every four hours. The medication per their procedure for after hydrocodo every four hours after hydrocodo every four hours. The medication was not until the next morning the hydrocodo.	T is not met as evidenced on, interviews and record nined the facility failed to (#13), not in the selected on significant medication was admitted, on 06/10/10 5 PM, with a physician's ne/Lortab (narcotic) for pain ne facility failed to obtain the established policy and nours delivery. The pain received or administered, g, on 06/11/10, at AM. Findings include:			administration.  With respect to how the facility of performance to ensure that solus sustained: Nursing management MAR/TAR daily for three weeks documentation of assessment periodication administration is continuously Management will audit administration.	utions are nt will audit to ensure rior to npleted.	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION	(X3) DATE S COMPLE	URVEY TED
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	PROVIDER OR SUPPLIER AND VILLA CARE AN	D REHABILITATION CENTER	·.	STREET ADDRESS, CITY, STATE, 8005 US HWY 60 WEST LEWISPORT, KY 42351		1/2010
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F 333	Service Agreement' facility's policy for "pumbers/hours and 10/15/05, revealed pharmacy to provide deliveries to the facility on the facility failed to repeat the facility could obte from a third party pharmacy failed to remain the facility could obte from a third party pharmacy hours of 8:00 AM until 5:30 FPM and 8:00 AM until 5:30 FPM and 8:00 AM until cut-off time of 3: for delivery was masservice. In an emerichecked the emerger was not available, the with the pharmacy as STAT situation and as and service of the service of	ity's "Pharmacy Products and ', dated 09/13/07 and the oharmacy telephone order cut off times", dated an agreement for the e "prompt and timely" litty. Deliveries would be ur before and/or after the me. In the event the make a delivery as required, ain delivery of the medication harmacy provider or request ery of medication. The operation were identified as PM, with a order cut off at 5:30 til 3:30 PM on Saturdays, with 30 PM. After hours request de through the answering gency, the nursing staff ency kit and if the medication he nurse should communicate and inform the pharmacy of a a special delivery would be or nursing staff member could	F	procedures per gastro times per week for the compliance. The resi to the Performance in tee for review with rec ongoing monitoring as Compliance date: 7/2 F333 The facility will of that residents are free medication errors. With respect to reside alleged deficient pract was discharged home With respect to reside tial to be affected by t practice: 07/01/10, a Cart audit was comple medications were ava DNS and Administrate	ree weeks to ensure ults will be submitted approvement Committed approvement Committed approvement and sindicated.  2/10 continue to ensure a of any significant approvement and the side approvement and the side approvement and the side and	
	06/10/10, from the h diagnoses which inc disease), Neutrophil lesions), Chronic Lo Deformity of the Lur Degenerative Joint I and L5-Sacrum (S) included Suspect Co Posterior Horn of Me	dmitted to the facility on acspital setting, with soluted Lupus (autoimmune ic Eccrine Hydradenitis (skin w Back Pain, Compression and Cisease of the Spine at L4-L5 Additional diagnoses of the Spine at L4-L5 and Disease of the D				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SI COMPLE	
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NAME OF F	ROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE		
Helpri	ADDUNCT A CARP AN	D DELLA DE LEATION OF LEED			005 US HWY 60 WEST	: .	
HEARTL	AND VILLA GARE AN	D REHABILITATION CENTER		L	EWISPORT, KY 42351	,	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	(QI	ــــــ	PROVIDER'S PLAN OF CORRECT	TION	(X5)
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 333			.F	333	With respect to measures to eff	ect system	Ī
,		ission Nursing Assessment,			ic changes to ensure the allege	d deficient	•
		ealed the resident expressed			practice does not recur: All Lice	ensed	
		ncing pain, had a pain history	•		Nurses have been re-educated	on the	
		ed pain medication. A review dministration Record (MAR).			facility guideline (Quick Referer		
j		evealed no medications,			QRG) for medication not availa		
		cations, were administered to			clude ordering of medications a		
	Resident #13, on 06				admission and new orders, pha		-
	7		٠		off times, CMA communication		
		esident #13, on 06/29/10 at			•		
		AM, revealed he/she was		ļ	Licensed Nurse (LN), use of 24		
٠,		ity from the hospital, on noon. The resident stated		-	port, validation of medications o		
		pain" and the nurses		į	received, what to do when not r		
		m/her the prescribed pain	•	ļ	use of back up pharmacy, and t	notification	:
!		rive in the next pharmacy		į	of the physician, completed on	07/03/10	
	delivery, at 8:00 PM				by DNS. The Quick Reference	Guide	-
		ome and she did not receive			(QRG) was laminated and place	ed in front	
		the next day. Resident #13			of each MAR book for "medicati	on not	
		experienced as "worse than			available on 07/01/10, Nurse/Cf	i	
,		nbearable". Also, Resident n he/she asked for pain		- 1	orientation will include medication		_
		felt he/she "was a pain to			ment with the QRG for medicati	- 1	
		aff). A (phone) interview with		Ì	available guideline.	on not	
		/01/10 at 1:45 PM, (the		.		أمانح مصالات	
		rged on 06/29/10), revealed it			With respect to how the facility v	· I	
į		rstand why it took so long to		!	performance to ensure that solu		
. !		when the pharmacy was		1	sustained: Nursing Manageme		
:		from the facility, Resident		•	audit MAR's daily for four weeks		
• •		ain he/she experienced while	-		ness of medication administration	n.	
i		on as, "sitting in a bed of hot			Nursing Management will revie	w/audit all	
. [		sident also expressed a		:	new admission/readmissions fo	r timely 🔻	
		ld people who might not be		i	delivery of medications for four	weeks.	
	getting their medical				An AD Hoc QA meeting was he	1	
		ì			07/07/10, with the Medical Direc	1	
		ensed Practical Nurse (LPN)	•		telephone. The results will be s	, t	
. [		pproximately 9:00 AM,					. ,
1	revealed she admitte	ed Resident#13. on 06/10/10.		- 1	to the Performance Improvemer	R (F1)	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE S COMPLE	
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	PROVIDER OR SUPPLIER  AND VILLA CARE AN	D REHABILITATION CENTER	-	86	REET ADDRESS, CITY, STATE, ZIP CODE 1006 US HWY 60 WEST EWISPORT, KY 42351		
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F 333	The facility received medication orders, I However, the facility	a faxed copy of the resident's orior to Resident #13's arrival, r awaited an actual copy of the	F	333	committee for review with reco tions and be monitored for thre through the PI process and on indicated.	e months	
	pharmacy. Additional facility and wrote a particular (Lortab) 10/325 millibe administered every was not delivered as was no medication in equivalent to the presention in the present and the	en faxed the orders to the ally, the physician came to the prescription for Hydrocodone grams (mg) (two tablets) to ary four hours. The medication is expected that day and there in the emergency box escribed dosage. LPN #3			Compliance date: 7/22/10	}	
	stated Resident #13 degree of pain".	was "continually in some				•	·
	approximately 3:00 nights and pharmac at approximately 12: accepted the deliver receipt. LPN #2 sta medications, to inclu (Lortab) were not incevening of 06/10/10 recall any specifics of	with LPN #2, on 06/30/10 at PM, revealed she worked y orders are usually delivered 00 AM (midnight) daily. She ies and signed the delivery ted Resident #13's ide the pain medication, cluded in the delivery, the LPN #2 stated she did not of pain experienced by as sure he/she experienced		* ( ** 4 ******************************			
	pain, due to a diagno	oses of "Spinal Collapse".  Assistant Director of Nursing	*1, *			,	
and the second s	(ADON), on 07/01/19 revealed she-worked shift, on 06/10/10. The not recall Resident # introducing herself to "welcome speech".	O at approximately 8:55 AM, I the 6:00 PM to 10:00 PM the ADON stated she could the resident and giving the The ADON stated she was reders were faxed to the		A CA CAA MACCAMANAMAAAAAA		771 111	
	Pharmacy, on 06/10 "looked at the fax looked	/10 at 3:13 PM, because she					
	ANT BUTCH A FORM AND THE	Director of Adiating (DOM),					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SI COMPLE	JRVEY ETED
	-	185399	B. WIN	1G	*	07/0	1/2010
	ROVIDER OR SUPPLIER AND VILLA CARE AN	D REHABILITATION CENTER		80	EET AODRESS, CITY, STATE, ZIP CODE 105 US HWY 60 WEST EWISPORT, KY 42351		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION ··DATE
F 333	she did not know where the did not know where the pair was no medication to 06/10/10.  A review of the phare 06/11/10 at 5:43 AM twelve (12) tablets of the phare the pair where the phare the phare of the phare the ph	ge 5 oximately 9:00 AM, revealed then Resident #13 actually n medication, but knew there available for the resident, on macy delivery receipt, dated the revealed the delivery of of Hydrocodone 10/325, for	F3	333			
	ACCURATE PROCE The facility must prodrugs and biological them under an agre §483.75(h) of this paunicensed personnel aw permits, but only supervision of a lice.  A facility must provide (including procedure acquiring, receiving, administering of all of the needs of each reality must em a licensed pharmacion all aspects of the services in the facility.	ovide routine and emergency is to its residents, or obtain ement described in art. The facility may permit el to administer drugs if State y under the general nsed nurse.  The facility may permit el to administer drugs if State y under the general nsed nurse.  The facility may permit el to administer drugs if State drugs are services es that assure the accurate dispensing, and drugs and biologicals) to meet esident.  The facility may permit el to administer drugs are dispension and biologicals el to meet esident.  The facility may permit el to administer drugs if State	F4	25	F425 The facility will continue to routine and emergency drugs a biologicals to its residents, or of under an agreement. The facility provide pharmaceutical services the needs of each resident. The will obtain the services of a lice pharmacist who provides constall aspects of the provision of provides in the facility.  With respect to resident(s) affect alleged deficient practice: Resident #11's physician and reparty notification of missed dost tensive medication and glaucor drop was completed on 07/01/10 DNS with no new orders received With respect to residents having potential to be affected by the adeficient practice: 07/01/10, a deficient practice: 07/01/10, a	and btain them ity will is to meet ie facility insed ultation on harmacy cted by the ident #13 9/10. esponsible se of hype ma eye 10 by the ed. g the alleged	
	by:	T is not met as evidenced and record reviews, it was ty failed to provide			Medication cart audit was com	pleted to	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE S COMPLI	
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		185399				07/0	1/2010
	PROVIDER OR SUPPLIER AND VILLA GARE AN	D REHABILITATION CENTER		80	EET ADDRESS, CITY, STATE, ZIP COD 005 US HWY 60 WEST EWISPORT, KY 42351		
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F 425	Continued From pa	de 6	F	125			
r 425	that assure the accidispensing, and adribiologicals) to meet (#11), in the selecter resident (#13), not ifacility failed to follo procedures to obtain the event the medic routine delivery. The prescribed medication administration for Refacility failed to administration for Resident #13 description for the prescribed pain mee PM, 06/11/10 at 12: Resident #13 description not having paint this time period as "unbearable". Additional administer Resident hypertensive medical	vices (including procedures urate acquiring, receiving, ministering of all drugs and the needs of one resident d sample of 12, and one in the selected sample. The witheir established policy and in the needed medications in ation was not included in the e facility failed to ensure ons were available for esidents #13 and #11. The inister Resident #13's dication on 06/10/10 at 8:00 00 AM and at 4:00 AM. Without the pain experienced in medications available during worse than excruciating and ionally, the facility failed to it #11's prescribed ation at 8:00 PM and for the treatment of	<b>+</b> 4	125	ensure all medications were house by the DNS and Admi With respect to measures to changes to ensure the alleg-practice does not recur: All L Nurses have been re-educat facility guideline (Quick Refe QRG) for medication not avainclude ordering of medication admission and new orders, poff times, CMA communication use of 24 hour report, validatications ordered and received when not received, use of baland notification of the physicion.07/03/10 by DNS. Pharm completed re-education on CLN/CMA's "Back to Basics".	nistrator. effect systemied deficient icensed ed on the rence Guide; ilable to ons at time of sharmacy cut on with LN, ion of med- d, what to do ck pharmacy, ian, completed hacy 07/22/10, for The Licensed I medications	
	Findings include:				from the pharmacy is to valid medications ordered that day	were delivere	:d
The state of the s	Service Agreement" facility's policy for "p numbers/hours and 10/15/05, revealed a pharmacy to provide deliveries to the faci made within one hospecified delivery tir pharmacy failed to r the facility could obt	order cut off times", dated an agreement for the "prompt and timely" lity. Deliveries would be ur before and/or after the		The second section of the second section of the second section	and administered as ordered medication not available guid		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION	(X3) DATE S COMPLE	URVEY ETED
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NAME OF F	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
HEARTL	AND VILLA CARE AN	D REHABILITATION CENTER		1	005 US HWY 60 WEST EWISPORT, KY 42351		
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F 425	Continued From page	ge 7	F	125	With respect to how the facility v	vill monitor	
	pharmacy hours of	operation were identified as			performance to ensure that solu		,
		M, with a order cut off at 5:30			sustained: Validation of reconcil		,
į		til 3:30 PM on Saturdays, with		İ	medication delivery will be revie		I
İ		30 PM. After hours request de through the answering	•	. ]	daily by Administrator/Nursing I		Ĭ l
		gency, nursing staff should	-		ment for four weeks. An AD Ho	-	
		by kit and if the medication					
		e nurse should communicate	** 1		meeting was held 07/01/10 with	(IIC	
		nform the pharmacy of a		- 1	Medical Director via telephone.  The results will be submitted to	ila a Di	
		a special delivery would be	•			Í	
	request a special de	or nursing staff member could			committee for review with recom	i	s · ·
'	request a special de	livery		- 1	and monitored for three months	, - :	
·	1. Resident #13 wa	s admitted to the facility, on			the PI Process and ongoing as I	ndicated.	
	06/10/10 at approxir			1	Completion Date: 7/22/10		
•		luded Lupus (autoimmune	•	- ;			
İ		lo Ecorine Hydradenitis (skin		-			
		w Back Pain, Compression hbar (L) 3, and Degenerative	:				
	Joint Disease of the						
-	L5-Sacrum (S) 1 (lov		•				
. [	diagnoses included	Suspect Complex Tear,					
		sterior Horn of Medial		:	•	Ì	
	Meniscus (knee), Hi			i			
1	Osteoarthritis of Mul	upie Joints.	1			· į	
	A review of the Admi	ssion Nursing Assessment,				i	1
	dated 06/10/10, reve	aled the resident expressed					
		cing pain, had a pain history	i.			Ì	
		d pain medication. A review		1			• 1
		ministration Record (MAR), vealed no medications,		:			
		ations, were administered to		•		1111	
	Resident #13, on 06						
ľ							
		sident #13, on 06/29/10 at				, <u> </u>	
		AM, revealed he/she was					
		y from the hospital, on noon. The resident stated				· ·	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILO	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		185399	B. WING	3	07/01/2010
	ROVIDER OR SUPPLIER AND VILLA CARE AN	D REHABILITATION CENTER	. 8	STREET ADDRESS, CITY, STATE, ZIP COO 8005 US HWY 60 WEST LEWISPORT, KY 42351	DE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE COMPLETION
F 425	(unidentified) told h medication would a delivery, at 8:00 PN medication did not of the medication until described the pain of excruciating and "till" attention where them (referred to some content was discharged pain medication located only an hou without the medication without the medication located the pwithout the medication without the medication with the medication without the medication without the medication without the medication without the medication without the medication without the medication without the medication with the medication with the medication with the medication with the medication with	ge 8 pain" and the nurses im/her the prescribed pain rrive in the next pharmacy I. However, the pain come and she did not receive the next day. Resident #13 experienced as "worse than inbearable". Also, Resident in he/she asked for pain felt he/she "was a pain to taff). A (phone) interview with r/01/10 at 1:45 PM, (the rged on 06/29/10), revealed it rstand why it took so long to , when the pharmacy was r from the facility. Resident ain he/she experienced while on as, "sitting in a bed of hot e/she,"didn't sleep all night,	F 42	25	
	An Interview with Lik #3, on 07/01/10 at a revealed she admitt The facility received medication orders, phowever, the facility medications and the pharmacy. Additiona facility and wrote a p(Lortab) 10/325 millibe administered every was not delivered as was no medication i equivalent to the prestated Resident #13 degree of pain". LP	censed Practical Nurse (LPN) pproximately 9:00 AM, ed Resident #13, on 06/10/10, a faxed copy of the resident's prior to Resident #13's arrival, awaited an actual copy of the in faxed the orders to the faxed the orders to the faxed the orders to the prescription for Hydrocodone grams (mg) (two tablets) to faxed the tablets) to faxed the physician came to the forescription for Hydrocodone grams (mg) (two tablets) to faxed the facility had forescribed dosage. LPN #3 forescribed			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE S COMPL	SURVEY ETED
	•	185399	8. WII	NG _		07/0	01/2010
NAME OF PR	OVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
HEARTLA	ND VILLA CARE AN	D REHABILITATION CENTER		8	005 US HWY 60 WEST EWISPORT, KY 42351		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 425	Continued From page	ge 9	F	425			
A e n d d d n () e r	An (phone) Interview approximately 3:00 aights and pharmace lelivered at approximately. She accepted lelivery receipt. LP nedications, to include a location of 06/10/10 acall any specifics of tesident #13, but we receive a location of the lesident #13, but we receive and specifics of the location of t	w with LPN #2, on 06/30/10 at PM, revealed she worked y orders were usually mately 12:00 AM (midnight) I the deliveries and signed the N #2 stated Resident #13's ude the pain medication, cluded in the delivery, the LPN #2 stated she did not of pain experienced by as sure he/she experienced		· · · · · · · · · · · · · · · · · · ·			
A (/ re s n in "\	In interview with the ADON), on 07/01/1/ evealed she worked hift, on 06/10/10. The call Resident stroducing herself to velcome speech".	e Assistant Director of Nursing 0 at approximately 8:55 AM, 1 the 6:00-PM to 10:00 PM the ADON stated she could 13's pain, but remembered to the resident and giving the The ADON stated she was refers were faxed to the /10 at 3:13 PM, because she	. Š	** *** A WASHINGTON			
st do	coked at the fax log ated routine orders expected to arrive by asident required a promed that it was nome medications was allowed the Pharmacy elivered, but "just not interview with the not 07/01/10 at appropedid not know who ceived his/her pain	g, on 07/01/10". The ADON faxed to the Pharmacy were 10:30 PM to 11:00 PM. If a pain pill the pharmacy was needed the same evening. Were available in the kept by the facility. She was getting medications					

OF IA I P	VO LOU MEDIOVUE	A MEDICAID SERVICES									O1V	D NC	<u>, บูซูจู</u>	10-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A BU			CONST	RUCTIO	)N				DATE S COMPL		Y
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HEARTL	AND VILLA CARE AN	D REHABILITATION CENTER					VY 60 W RT, KY		51					
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	06/11/10 at 5:43 AM	rmacy delivery receipt, dated I, revealed the delivery of of Hydrocodone 10/325, for		•								,		
	Manager of the Pha AM and at 10:20 AM orders for Resident the Pharmacy, at 5:: off time for receipt of General Manager st received the fax "mi computer screen an Additionally, a call w from the facility, at 1 requesting the medi pharmacy. Howeve not receive the notic General Manager st	inducted with the General rmacy, on 07/01/10 at 9:50 ff, revealed the physician #13 was received by fax at 22 PM on 06/10/10. The cut of ordered was 5:30 PM. The ated he thought whoever as clicked" something on the dideleted the order. It is example to the pharmacy 1:36 PM on 06/10/10, cation from the back up received at the pharmacy did it is until 2:30 AM. The ated, "for the same reason as The pharmacy delivered the											THE PROPERTY OF THE PROPERTY O	
.	medication at 5:43 A 2. Resident #11 was 06/14/10 with diagnot Heart Failure, Hyper review of Resident # 06/14/10 and printed for Hydralazine Hydr blood pressure) 50 r three times a day, so AM, 1:00 PM, and 8: resident's admission medication Lumigan		· · · ·		The state of the s									

F 425 Continued From page 11 A review of Resident 11's Medication Administration Record, for June 2010, revealed the Hydralazine HCL 50 mg nor the Lumigan 0.03% was administered, on 08/14/10 at 8:00 PM.  An interview with the Certified Medication Technician (CMT) #1, on 07/01/10 at 1:35 PM, revealed the pharmacy did not deliver the medications on 08/14/10 and therefore, she was unable to administer the medications for Resident 11. CMT #1 stated she informed the charge nurse regarding the unavailability of the medications was delivered in time, for the 8:00 PM medication swas delivered in time, for the 8:00 PM medications was delivered in time, for the 8:00 PM medication problems due to the pharmacy's fallure to ensure delivery of medications was delivered in time, for the 8:00 PM medication profile of 06/14/10. She indicated on the fax the fact the resident was a new admission and requested the pharmacy send the medications early. LPN #1 stated the pharmacy frequently failed to deliver medications timely, with deliveries from the pharmacy usually occurring between 10:30 PM and midnight.  An interview with the General Manager of the pharmacy, on 07/01/10 at 2:30 PM, revealed the pharmacy recived the faxed medication orders to resident #11, at 1:57 PM on 06/14/10. The delivery of the medications was made, at 12:22 AM on 106/15/10. The General Manager stated the pharmacy attempted to work with the facility to ensure medications was made, at 12:22 AM on 106/15/10. The General Manager stated the pharmacy attempted to work with the facility to ensure medications were delivered to meet the		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONST	RUCTION		<del> </del>	(X3) DATE :	
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HEARTLAND VILLA CARE AND REHABILITATION CENTER  C(XI) ID PREFIX TAG  SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  FREFX TAG  CONTINUED From page 11  A review of Resident 11's Medication Administration Record, for June 2010, revealed the Hydralazine HCL 50 mg nor the Lumigan 0.03% was administered, on 06/14/10 at 8:00 PM.  An interview with the Certified Medication Technician (CMT) #1, on 07/01/10 at 1:35 PM, revealed the pharmacy did not deliver the medications on 06/14/10 and therefore, she was unable to administer the medications for Resident 11. CMT #1 steaded she informed the charge nurse regarding the unavailability of the medications. CMT #1 also stated the facility had experienced frequent problems due to the pharmacy's failure to ensure delivery of medications was delivered in time, for the 8:00 PM medication pass.  An interview with the Licensed Practical Nurse (LPN) #1, on 07/01/10 at 2:05 FM, revealed she faxed Resident 11's medication orders to the pharmacy, on the afternoon of 06/14/10. She indicated on the fax the fact the resident was a new admission and requested the pharmacy usually occurring between 10:30 PM and midnight.  An interview with the General Manager of the pharmacy received the faxed medication orders for Resident #11, at 4:57 PM on 06/14/10. The delivery of the medication was made, at 12:22 AM on 06/15/10. The General Manager stated the pharmacy received the faxed medication orders for Resident #11, at 4:57 PM on 06/14/10. The delivery of the medication was made, at 12:22 AM on 06/15/10. The General Manager stated the pharmacy received the faxed medication orders for Resident #11, at 4:57 PM on 06/14/10. The delivery of the medication swere delivered to meet the			185399							07/	01/2010
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F 425	responsibility of the determine if the med	ge 12 licensed nursing staff to dication was essential and or call the pharmacy back.	F	125			
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#### PRINTED: 07/20/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 07/07/2010 185399 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8005 US HWY 60 WEST HEARTLAND VILLA CARE AND REHABILITATION CENTER LEWISPORT, KY 42351 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES COMPLETION DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS "This Plan of Correction is prepared and A Life Safety Code survey was initiated and submitted as required by law. By subconducted on 07/07/10 to determine the facility's mitting this Plan of Correction, Heartcompliance with Title 42, Code of Federal land Villa Care & Rehabilitation Center Regulations, 482.41(b) (Life Safety from Fire) and does not admit that the deficiency listed found the facility not in compliance with NFPA 101 Life Safety Code 2000 Edition. Deficiencies on this form exist, nor does the Center were cited with the highest deficiency identified at admit to any statements, findings, aD. facts, or conclusions that form the basis K 144 NFPA 101 LIFE SAFETY CODE STANDARD K 144 for the alleged deficiency. The Center SS=D reserves the right to challenge in legal Generators are inspected weekly and exercised under load for 30 minutes per month in and/or regulatory or administrative accordance with NFPA 99. proceedings the deficiency, statements facts, and conclusions that form the basis for the deficiency." K 144 The facility will continue to test the emergency generator weekly per NFPA 99.3.4.4.1. With respect to resident(s) affected by the alleged deficient practice: No negative outcomes noted. This STANDARD is not met as evidenced by: Based on record review and staff interview With respect to residents having the conducted on 07/07/10, it was determined the potential to be affected by the alleged facility failed to exercise the generator under load deficient practice: Maintaince Director for 30 minutes per month as required by NFPA ensured the facility monitoring system 99. 3.4.4.1. supported the efficacy of the generator A review of the emergency generator log on under full load with a 15 minute cool 07/07/10; at 1:30 PM revealed the generator was down period. exercised under load for 15 minutes per month and not 30 minutes per month as required by NFPA. An interview conducted with the Maintenance Director on 07/07/10, at 1:35 PM revealed he did

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

If continuation sheet Page 1 of 2

7-22-10

(X6) DATE

Facility ID: 100679

not realize the generator had to be exercised for

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ILDING	ELE CONSTRUCTION  O1 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  ND VILLA CARE AND RI	EHABILITATION CENTER	•	80	EET ADDRESS, CITY, STATE, ZIP CODE 005 US HWY 60 WEST EWISPORT, KY 42351		
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K 144	Continued From page 1 at least 30 minutes per month under load.			144	With respect to measures to ef changes to ensure the alleged	• • •	¢
					practice does not recur: 7/7/10	-	
					load cycle timer was re-adjuste		
					minutes in addition to a 15 min		
		·		İ	down cycle. On 07/7/10 the ma		
		•			director was educated on NFP		
		. *			generator inspection and load t	•	
				İ	Administrator.		
					With respect to how the facility	will monitor	
				1	performance to ensure that so		
				:	sustained: The Maintenance D		
Wester				•	Environmental Services Directo	or will	
		•			monitor/record the monthly test	. The result:	3
					will be submitted to the Perform		
					Improvement (PI) committee fo	r review with	γ
1			ļ		recommendations and be monl		
		•		Ì	three months through the PI pro	ocess and	•
		•			ongoing as indicated.		
-			'.		Compliance Date	7/22/10	7/22/10
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